KPIs for Consideration

for use by Multi-Regional Collaborative

Summary

This paper proposes 16 measures for consideration as initial key performance indicators (KPI) for use in the Multi-Regional Collaborative's Data Analytics project. The proposed measures fall into the following focus areas:

- *Comprehensive Diabetes Care*
- *Screening and Monitoring for People Using Antipsychotics*
- *Tobacco Use and Treatment*
- *Engaging Primary Care*
- *Acute Care*

The full list of measures is included below, in the section below entitled: Proposed KPI for Consideration.

Criteria for Selection

The following criteria were considered in selecting a proposed set of measurements for use as KPI in the data analytics project:

1. **Standardized measure.** Is the measure a national standard, endorsed by NQF and used in one or more federal initiatives related to the public behavioral health care system?
2. **Built with existing data.** Can the measure be populated using existing data which will be processed as part of the base dataset included in the PIHPs' data analytics platform contract?
3. **Can be changed.** Are there clear steps which can be taken to improve performance on the measure, and which can be used to inform the development of alerts and other decision support within the platform?
4. **Strategic alignment.** Is the measure related to two key strategic initiatives of the behavioral health system: integrated health services or reducing the mortality gap for SMI?
5. **Cross-functional.** Can the measure be used to evaluate performance related to multiple functional areas of the PIHP and its member CMHSPs?

Use Standardized Measures

There are literally thousands of measures used throughout the United States (not to mention the world). The following criteria were used to initially filter a set of standardized measures for consideration by the collaborative:

- National Quality Forum (NQF) endorsement
- Relevance to one or more population currently served by PIHPs.
- Current or proposed use in federal programs (e.g. Medicaid core set, PQRS, Meaningful Use, Certified Community Behavioral Health Clinics).[1]
- Inclusion in NCQA's HEDIS measure set used in incentive arrangements
- Inclusion in standard measure sets related to national priorities (e.g. NQF's Behavioral Health measure set)

Aligning with standard measures used by existing initiatives not only allows for comparison but for collaboration and potential incentives. Some existing incentives related to these measure sets include:

- **Physician Quality Reporting System (PQRS).** For 2014, eligible providers must choose at least nine measures that span three of the following six domains.[2] Failure for Medicare providers to report in 2014 will result in a 2.0% penalty in 2016 and beyond.
- **Medicaid Core Measures.** This measure set has been around since 2012, but CMS is now urging states to use them in their Quality Improvement Strategies. It is likely that these measures will eventually be required.
- **Healthcare Effectiveness Data and Information Set (HEDIS).** Medicaid Health Plans such as Meridian and Molina offer incentives to providers based on HEDIS performance. Health plans, in turn, are incentivized for their performance.

Using these criteria, we developed a draft portfolio of measures which can be referenced here: Michigan PIHP Collaborative Portfolio. Subsets of measures in subsequent sections are drawn from this initial set, with the exception of two HEDIS measures explicitly related to current PIHP strategic priorities.[3]

[1] Special consideration for measures supported by the Measure Applications Partnership (MAP), which provides input to HHS and private sector initiatives on measures for use in public reporting, performance-based payment, and other programs.

[2] The process and requirements for reporting are available at 2014 PQRS Measure-Applicability Validation (MAV) Process for Claims and Registry-Based Reporting of Individual Measures: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html

[3] These measures are: Children and adolescents' access to primary care practitioners (CAP) and Adults' access to preventive/ambulatory health services

Use Existing Data

In order to populate electronic measures, selected measures must be calculated using available data and not require chart review, mapping data from disparate EMRs or other data sources. Datasets available for use in measure development include: the MDCH Data Extract file, QI File, MDCH Eligibility Files (834).

The system also includes the following reference sets for linking and grouping elements from the datasets listed above: Clinical Classifications Software (CCS), Chronic Condition Indicator (CCI), NPPES (Providers), ICD9/10 Codes, NDC Drug Database, AMA CPT/HCPCS Codes, LOINC, SNO-MED Codes.

Appendix 1 shows the 40 measures which can be calculated using the existing datasets mentioned above. Subsequent sections will consider subsets of this list, to ensure that we are focusing on measures that are possible to calculate.

While some of these data elements are available in the claims data, several of them require codes that are not commonly used, and which would therefore require changes in coding practice in order to get an accurate picture of performance. These 11 measures were excluded and are listed below:

Category	Measure Title	NQF#
Comprehensive Diabetes Care	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	0059, 2607
	Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	0061, 2606
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	0575, 2608
Blood Pressure Control	Ischemic Vascular Disease (IVD): Blood Pressure Control	0073
	Controlling High Blood Pressure (CBP)	0018, 2602
Obesity	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	0421, 2601

These measures require the use of HCPCS and ICD-9 codes that are not consistently used. Unfortunately, these also happen to be the measures that address health outcomes, as opposed to process. While processes are intended to impact outcomes and can serve as a helpful start, it is our recommendation that planning begin to consider how data to populate outcome measures such as the ones above will be integrated into the analytics platform, either through new data feeds from EMRs or changes in coding practice on claims.

Impact, Integration Strategy & Health Plan Functions

Of the measures that are possible, we looked at those which met the following criteria:

Impact. Clear steps can be taken to improve performance on the measure, and to inform the development of alerts and other decision support within the platform.

Three of the remaining 29 measures were determined to have low potential for impact and were removed, either because (a) they were outside of the PIHP's sphere of influence with their existing provider network, (b) they were outcomes without clear knowledge of how to influence improvement, or (c) both.[4]

Cross-functional. Next, we considered whether the measure can be used to manage performance across multiple functional areas of the PIHP and its member CMHSPs. Measures were mapped to one or more of the following PIHP functions: integrated care (IC), quality improvement (QI) and utilization management (UM).

Eight of the remaining 26 measures were only related to a single PIHP function: quality improvement.[5] These were removed to allow focus on measures with broader use.

Integration Strategy. Here, we considered whether the measure can be used to monitor progress in integrating health services or reducing the mortality gap for SMI.

- *Mortality Gap:* The most recent review of the evidence[6] suggests that the median years of potential life lost due to mental illness is 10 years and that 14.3% of deaths worldwide (approximately 8 million per year) are attributable to these disorders. Yet the causes of death for these individuals are the same chronic conditions as the rest of the population, which means that it may be possible to impact mortality by focusing on behaviors such as smoking, substance use, physical inactivity, metabolic side-effects and poor diet.
- *Integrated Care:* Care models that integrate mental health, substance abuse, and primary care services are viewed as the most promising approach to addressing the population's multiple healthcare needs. There are multiple levels and types of integrated care models,[7] including health home pilots currently underway in multiple CMHSPs.

After applying our most recent filter above, 18 measures were left. 3 of these were not directly related to integration strategies and were removed from consideration. Since there are other requirements that may prompt adoption of KPIs, these three measures are listed below for consideration:

Measure Title	NQF#
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	0004
Follow-Up After Hospitalization for Mental Illness (FUH)	0576
Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)	1937

[4] The following measures were removed in this step: NQF #s 0018, 0056, 2371.

[5] The following measures were removed in this step: NQF #s 0105, 0108, 1365, 0022, 1880, 2337, 2111, 1879

[6] Walker ER, McGee RE, Druss BG. Mortality in Mental Disorders and Global Disease Burden Implications: A Systematic Review and Meta-analysis. JAMA Psychiatry. 2015 Feb 11. doi: 10.1001/jamapsychiatry.2014.2502. [Epub ahead of print]

[7] You can read more at the SAMHSA-HRSA Integrated Care site: http://www.integration.samhsa.gov/integrated-care-models

Proposed KPI for Consideration

What remains after focusing our approach are the following 16 measures, grouped by area of focus. The measures fall into some coherent categories, and several of the health-related measures have variants related specifically to mental illness diagnoses. Out of these proposed measures, the phase 1 project requires selecting 5 KPI as an initial set.

Category	Measure Title	NQF#
Comprehensive Diabetes Care	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	0057, 2603
	Comprehensive Diabetes Care: Eye Exam (retinal) performed	0055, 2609
	Comprehensive Diabetes Care: Medical Attention for Nephropathy	0062, 2604
Screening and Monitoring for People Using Antipsychotics	Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotics	1927
	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	1932
	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	1933
	Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	1934
Tobacco Use and Treatment	Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	2600
	Medical Assistance With Smoking and Tobacco Use Cessation (MSC)	0027
Engaging Primary Care	Children and adolescents' access to primary care practitioners (CAP)	NA
	Adults' access to preventive/ambulatory health services	NA
Acute Care	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	2605
	Plan All-Cause Readmissions (PCR)	1768

Substantial Gaps

There are clear gaps in the set of KPIs outlined in this proposal, which include the following:

- Cost and Resource Measures
- Measures related to people with Developmental Disabilities
- Measures related to clinical processes for behavioral health treatment
- Functional Outcome Measures
- Person and Family Centered Care Measures
- Safety Measures

Standard measures exist in some of these areas, but most have not yet been included in incentive programs such as the ones referenced above. These gaps will need to be addressed, both through adoption of existing measures and/or development of new measures using standard formats. A strategic approach to building a comprehensive measurement portfolio within the data analytics system will help to address gaps in organizational knowledge.

Appendix 1: Possible measures with existing data

Measure Title	NQF#	NQF BH	PQRS	MAP	MUS2	HEDIS	Medicaid	CCBHC
Controlling High Blood Pressure (CBP)	0018		■	■	■	■	■	■
Initiation and Engagement of Alcohol and Other Drug Dependence Treatmt (IET)	0004		■		■	■	■	■
Antidepressant Medication Management (AMM)	0105		■		■	■	■	■
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	0108	■	■		■	■		■
Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	1365	■	■		■			■
Comprehensive Diabetes Care: Eye Exam (retinal) performed	0055		■	■	■	■		
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	0059		■		■	■	■	
Medical Assistance With Smoking and Tobacco Use Cessation (MSC)	0027					■	■	■
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	0057					■	■	■
Diabetes: Foot Exam	0056		■		■	■		
Cardio Screening for People w/ Schiz or Bipolar Disorder Prescribed Antipsychotics	1927					■		■
Cardiovascular Monitoring for People With Cardio Disease & Schiz (SMC)	1933					■		■
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1879						■	■
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	0421		■					■
Follow-Up After Hospitalization for Mental Illness (FUH)	0576					■	■	
Plan All-Cause Readmissions (PCR)	1768					■	■	
Use of High-Risk Medications in the Elderly (DAE)	0022				■	■		
Comprehensive Diabetes Care: Medical Attention for Nephropathy	0062				■	■		
Children and adolescents' access to primary care practitioners (CAP)	NA					■	■	■
Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	1880							■
Antipsychotic Use in Children Under 5 Years Old	2337							■
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	0061					■		
Ischemic Vascular Disease (IVD): Blood Pressure Control	0073					■		
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	0575					■		
Diabetes Screening for People With Schizophrenia or Bipolar Using Antipsychotics (SSD)	1932					■		
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	1934					■		
Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)	1937					■		

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Annual Monitoring for Patients on Persistent Medications	2371						■	
Antipsychotic Use in Persons with Dementia	2111			■				
Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	2600	■						
Body Mass Index Screening and Follow-Up for People with Serious Mental Illness	2601	■						
Controlling High Blood Pressure for People with Serious Mental Illness	2602	■						
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing	2603	■						
Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy	2604	■						
Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	2605	■						
Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)	2606	■						
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	2607	■						
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)	2608	■						
Diabetes Care for People with Serious Mental Illness: Eye Exam	2609	■						
Adults' access to preventive/ambulatory health services	NA							■

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